OTHER SERVICES		
	Participating Provider	**Non-Participating Provider**
Ambulance service (including air ambulance)	The Corporation pays 70% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 30% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 70% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member must pay the balance of the Provider's charge
Durable Medical Equipment, Prosthetics* and Orthopedic Devices (if purchase or rental of Durable Medical Equipment is $500 or more, Pre-Authorization is required) *Prosthetics are covered up to a Maximum Payment of $50,000 per Member per Benefit Year.	The Corporation pays 70% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 30% of the Allowable Charge after meeting the Member's Benefit Year Deductible	Non-Covered
Medical Supplies	The Corporation pays 70% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 30% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Home Health Care, including private duty nursing services, limited to 60 visits per Benefit Period (Pre-Authorization is required)	The Corporation pays 70% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 30% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Hospice Care, limited to 6 months per episode (Pre-Authorization is required)	The Corporation pays 70% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 30% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	Non-Participating Provider
Colorectal Cancer Screenings limited to: • One (1) fecal occult blood testing of three (3) consecutive stool samples per Benefit Year • One (1) flexible sigmoidoscopy every five years • One (1) double contrast barium enema every five years	Covered	Covered
Colonoscopy (Diagnostic and Preventive)	The Corporation pays 100% of the Allowable Charge	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Colonoscopy (services related to the colonoscopy)	The Corporation pays 70% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 30% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Behavioral Therapy (ABA) related to Autism Spectrum Disorder limited to: • Members diagnosed at age eight (8) or younger • Members under the age of sixteen (16) • $52,100 per Benefit Year Pre-Authorization is required.	The Corporation pays 70% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 30% of the Allowable Charge after meeting the Member's Benefit Year Deductible	Non-Covered
Radiation therapy Cancer chemotherapy Respiratory therapy Pre-authorization is required	The Corporation pays 70% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 30% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	Non-Participating Provider
Provider Charges for physical therapy and occupational therapy (Limited to a combined 30 visits per Member per Benefit Year. Please see the "Outpatient Rehabilitation" section in Article III of the Plan of Benefits for further limitations)	The Corporation pays 70% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 30% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Speech therapy (Limited to 20 visits per Member per Benefit Year. Please see the "Outpatient Rehabilitation" section in Article III of the Plan of Benefits for limitations)	The Corporation pays 70% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 30% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Human organ and tissue transplant services (excluding drugs) Human organ and tissue transplant services are only covered if provided at a Blue Distinction Center of Excellence or a transplant center approved by the Corporation in writing Physician Charges are subject to the Benefit Year Deductible.	The Corporation pays 70% of the Allowable Charge The Member pays the remaining 30% of the Allowable Charge	Non-Covered
Allergy Injections	The Corporation pays 70% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 30% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Acupuncture	Non-Covered	Non-Covered
Cosmetic Services	Non-Covered	Non-Covered
Disease Management Program	Covered	Non-Covered

	Participating Provider	Non-Participating Provider
Chiropractic Services, including related x-rays, modalities and office visits, limited to a $1,000 maximum payment per Member per Benefit Year	The Corporation pays 70% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 30% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Health Questions Hotline	Covered	Non-Covered
Hearing Aids	Non-Covered	Non-Covered
Oxygen (Pre-authorization is required)	Covered	Covered
Impacted tooth removal	The Corporation pays 70% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 30% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Infertility treatment	Non-Covered	Non-Covered
Impotence treatment	Non-Covered	Non-Covered
Online Health Assessment Program	Covered	Non-Covered
Massage Therapy	Non-Covered	Non-Covered
Maternity Management Program	Covered	Non-Covered
Tobacco Cessation Program	Non-Covered	Non-Covered
Temporomandibular Joint Disorder (TMJ) including treatment	Non-Covered	Non-Covered
Orthognathic surgery	Non-Covered	Non-Covered
Weight Control Program	Non-Covered	Non-Covered

	Participating Provider	Non-Participating Provider
Sustained Health services related to an annual physical exam (limited to $300 per Member per Benefit Year) This benefit does not include Preventive Benefits offered under PPACA. See the Preventive Benefits section in this Schedule of Benefits for payment of Preventive Benefits under PPACA.	The Corporation pays 100% of the Allowable Charge after the Member pays the $30 Copayment	Non-Covered

PREVENTIVE BENEFITS The Benefit Year Deductible does not apply to these Benefits		
	Participating Provider	**Non-Participating Provider**
Preventive Benefits under PPACA (Refer to www.healthcare.gov for guidelines)	Covered	Non-Covered
Pap smear screenings (the report and interpretation only, limited to one (1) per Benefit Year)	The Corporation pays 100% of Allowable Charge	Non-Covered
Prostate screenings (limited to one (1) per Benefit Year)	The Corporation pays 100% of Allowable Charge	Non-Covered
In South Carolina:		
	SC Mammography Network	**All Other Providers**
Mammography screenings (limited to one (1) per Benefit Year for any female Member age 40 or older)	The Corporation pays 100% of Allowable Charge	Non-Covered
Outside South Carolina:		
	Out-of-State Participating Providers	**All Other Providers**
Mammography screenings (limited to one (1) per Benefit Year for any female Member age 40 or older)	The Corporation pays 100% of Allowable Charge	Non-Covered

PRESCRIPTION DRUG BENEFIT			
Prescription Drugs	**Mail Service Pharmacy**	**Participating Pharmacy**	**All Other Pharmacies**
Generic Drugs	$30 Copayment per Member for each Prescription or refill, up to a 90-day supply	$15 Copayment per Member for each Prescription or refill, for each monthly supply, up to a 90-day supply	Non-Covered
Preferred Brand Drug	$80 Copayment per Member for each Prescription or refill, up to a 90-day supply	$35 Copayment per Member for each Prescription or refill, up to a 31-day supply	Non-Covered
Non-Preferred Brand Drug	$140 Copayment per Member for each Prescription or refill, up to a 90-day supply	$60 Copayment per Member for each Prescription or refill, up to a 31-day supply	Non-Covered
Prescription Drugs used for tobacco cessation	Non-Covered	Non-Covered	Non-Covered
Prescription Drug Deductible	$0 (No Prescription Drug Deductible)	$0 (No Prescription Drug Deductible)	Non-Covered
Prescription Drug Out-of-Pocket	$0 (No Prescription Drug Out-of-Pocket)	$0 (No Prescription Drug Out-of-Pocket)	$0 (No Prescription Drug Out-of-Pocket)
Maximum Prescription Drug Benefit	$0 (No Maximum Prescription Drug Benefit)	$0 (No Maximum Prescription Drug Benefit)	Non-Covered
Prescription Drugs used for obesity/weight control	Non-Covered	Non-Covered	Non-Covered
Diabetic syringes and supplies	Covered	Covered	Non-Covered

Prescription Drugs	Mail Service Pharmacy	Participating Pharmacy	All Other Pharmacies
*Contraceptives: Generic oral contraceptives, generic injections, Mirena IUD, Nexplanon implant, Ortho Evra patch, Nuvaring, Ortho Flex, Ortho Coil, Ortho Flat, Wide-seal, Omniflex, Prentif and Femcap-vaginal	Prescription Drugs will be covered at 100%, up to a 90-day supply	Prescription Drugs will be covered at 100%, up to a 31 day-supply	The Member will be responsible for 100% of the Allowable Charge at the pharmacy, then will be reimbursed at 100%, up to a 31-day supply
**All Other Contraceptives (Prescription Drugs)	Covered	Covered	Non-Covered

***Contraceptives listed above are covered under the participating medical benefits at the same payment levels. Refill quantities for the contraceptives listed above may vary.**
****All other contraceptives are paid at the Generic, Preferred Brand and Non-Preferred Brand Drug payment levels.**

SPECIALTY DRUG BENEFIT		
	Participating Pharmacy	**All Other Pharmacies**
Specialty Drugs	$100 Copayment per Member for each prescription or refill, up to a 31-day supply	Non-Covered

VISION SCHEDULE OF BENEFITS (Healthy Vision)		
Vision Care Services	**Participating Providers**	**Non-Participating Providers Allowance**
Exam with Dilation as Necessary	$15 Copayment	$35
Eye Examination Options:		
Standard Contact Lens Fit and Follow-up*	Up to $55	Non-Covered
Premium Contact Lens Fit and Follow-up**	10% off retail price	Non-Covered
Frames (Any available frame at provider location)	$110 allowance, 20% off balance over $110	$55
Standard Plastic Lenses:		
Single Vision	$0 Copayment	$25
Bifocal	$0 Copayment	$40
Trifocal	$0 Copayment	$55
Lens Options:		
UV Coating	$15	Non-Covered
Tint (Solid and Gradient)	$15	Non-Covered
Standard Scratch-Resistance	$15	Non-Covered
Standard Polycarbonate	$40	Non-Covered
Standard Anti-Reflective Coating	$45	Non-Covered
Standard Progressive (Add-on to Bifocal)	$65	Non-Covered
Other Add-Ons and Services	20% off retail price	Non-Covered

* **Standard Contact Lens Fitting - spherical clear contact lenses in conventional wear and planned replacement (Examples include but not limited to disposable, frequent replacement, etc.)**

** **Premium Contact Lens Fitting - all lens designs, materials and speciality fittings other than Standard Contact Lenses (Examples include toric, multifocal, etc.)**

Vision Care Services	Participating Providers	Non-Participating Providers Allowance
Contact Lenses:		
Conventional	$0 Copayment, $110 allowance, 15% off balance over $110	$88
Disposable	$0 Copayment, $110 allowance, plus balance over $110	$88
Medically Necessary	$0 Copayment, Paid-in-Full	$200
Frequency:		
Examination	Once every 12 months	
Frame	Once every 24 months	
Lenses or Contact Lenses	Once every 24 months	

Additional Discounts:

- Member will receive a 20% discount on items not covered by the plan at Participating Providers, which may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed Provider's professional services, or contact lenses. Retail prices may vary by location.
- Discounts do not apply for benefits provided by other group benefit plans. Allowances are one-time use benefits; no remaining balance.
- Lost or broken materials are not covered.
- Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.
- Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA vision. Since Lasik or PRK vision correction is an elective procedure, performed by specially trained providers, this discount may not always be available from a provider in your immediate location. For a location near you and the discount authorization please call 1-877-5LASER6.
- After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com. The contact lens benefit allowance is not applicable to this service.

Plan Limitations/ Exclusions:

- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing,
- Plano non-prescription lenses and non-prescription sunglasses (except for 20% discount),
- Medical and/or surgical treatment of the eye, eyes, or supporting structures,
- Services or materials provided by any other group benefit providing for vision care,
- Services provided as a result of any Workers' Compensation law,
- Two pairs of glasses in lieu of bifocals,
- Aniseikonic lenses,
- Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under the plan,
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.